



FIELD OFFICE

MONTH/YEAR

NAME OF CLAIMANT	PROVIDER NUMBER
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ADDRESS	CITY	STATE	ZIP CODE
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*** PURPOSE OF TRIP	1. VISITATION	3. SCHOOL-RELATED ACTIVITY	5. TO/FROM PLACEMENT	7. MISC. FEES (i.e.parking, ferry etc.)
	2. COUNSELING	4. COURT HEARING	6. MEDICAL APPOINTMENT	8. OTHER (SPECIFY)

MILES	RATE 0.445	TOTAL REIMBURSEMENT	AUTHORIZATION NUMBER	DATE	INITIALS	SOCIAL WORKER APPROVAL
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SUPERVISOR APPROVAL _____